MEDI-CAL UPDATE

Medical Services
Bulletin 354

Billing and Policy
General Medicine Bulletin 354 **January 2004**

Contents

Articles with related Part 1 Manual Replacement Pages may be found in the "Program and Eligibility" bulletin. Articles with related Part 2 Manual Replacement Pages may be found in the "Billing and Policy" bulletin. The Medi-Cal Update *may not always contain a "Billing and Policy" section.*

Ibritumomab Tiuxetan (Zevalin): New Benefit

Effective for dates of service on or after April 1, 2004, Medi-Cal reimburses Yttrium-90 (Y-90) ibritumomab tiuxetan (Zevalin) injection (HCPCS code X7660) and Indium-111 (In-111) ibritumomab tiuxetan (HCPCS code X7662) when used to treat patients with relapsed or refractory low-grade follicular, or transformed B-cell non-Hodgkin's lymphoma refractory to treatment with rituximab 100 mg injection (HCPCS code X7634). The use of ibritumomab tiuxetan is subject to prior authorization and is limited to a maximum Units/Visits/Studies (U/V/S) of one unit for each code when billed by the same provider, for the same recipient and date of service.

Imaging and Therapy Protocol

Providers may be reimbursed for In-111 ibritumomab tiuxetan (HCPCS code X7662) and Y-90 ibritumomab tiuxetan (HCPCS code X7660) when treatment is administered under the following schedule:

Day 1: Imaging

- I.V. infusion of 250 mg/m² of rituximab (X7634)
- Within four hours – I.V. injection of In-111 ibritumomab tiuxetan (X7662) over a period of 10 minutes

Assessment of biodistribution:

- 1st image – 2 to 24 hours after injection of In-111 ibritumomab tiuxetan (X7662)
- 2nd image – 48 to 72 hours after injection of In-111 ibritumomab tiuxetan (X7662)
- 3rd image – 90 to 120 hours after injection of In-111 ibritumomab tiuxetan (X7662) (optional)

Days 7 – 9: Therapy

- I.V. infusion of 250 mg/m² of rituximab (X7634)
- Within four hours – I.V. injection of Y-90 ibritumomab tiuxetan (X7660) over a period of 10 minutes, not to exceed 32 mCi
  - 0.4 mCi/kg for patients with normal platelet counts
  - 0.3 mCi/kg for patients with platelet count of 100,000 – 149,000 cells/mm³

Please see **Ibritumomab**, *page 2*

Ibritumomab *(continued)*

Billing Requirements

Imaging Sequence

1. Rituximab 250 mg/m² (X7634) may be billed with CPT-4 code 96410 (chemotherapy administration, intravenous; infusion technique, up to one hour) and 96412 (…infusion technique, one to 8 hours, each additional hour).
2. In-111 ibritumomab tiuxetan (X7662) must be billed "By Report" with an attached copy of the manufacturer's (Zevalin) invoice and a description (including the name of the medication and dosage administered) entered in the *Reserved For Local Use* field (Box 19) of the claim or on an attachment. Failure to submit the invoice with the claim will result in the claim being denied.
3. CPT-4 code 78802 (radiopharmaceutical localization of tumor; whole body) may be billed per scan to a maximum of three.

Therapy Protocol

1. Rituximab 250 mg/m² (X7634) may be billed with CPT-4 codes 96410 and 96412.
2. Y-90 ibritumomab tiuxetan (X7660) may be billed with CPT-4 codes 77750 (infusion or instillation of radioelement solution) and 77790 (supervision, handling, loading of radiation source) and should be billed "By Report" with an attached copy of the manufacturer's invoice and a description (including the name of the medication and dosage administered) entered in the *Reserved For Local Use* field (Box 19) of the claim or on an attachment. Failure to submit the invoice with the claim will result in the claim being denied.

Prior Authorization

A *Treatment Authorization Request* (TAR) is required for treatment with Y-90 ibritumomab tiuxetan (X7660) and In-111 ibritumomab tiuxetan (X7662) and must include the following:

- A pathological report of a low-grade follicular or transformed B-cell non-Hodgkin's lymphoma
- Documentation that the recipient has undergone a chemotherapy regimen that included rituximab (X7634) and that the lymphoma was refractory or became refractory to the chemotherapy regimen; and
- Documentation that the platelet count of the recipient is not less than 100,000 cells/mm³.

The updated information is reflected on manual replacement pages chemo 14 and 15 (Part 2).

End Stage Renal Dialysis: Prior Authorization Update

Effective February 1, 2004, the following End Stage Renal Dialysis (ESRD) treatment codes no longer require prior authorization:

HCPCS Code	Description
Z6000	Maintenance dialysis including professional charges and routine laboratory services
Z6002	Maintenance dialysis including professional charges
Z6004	Maintenance dialysis including routine laboratory charges
Z6006	Maintenance dialysis only

Please see **Dialysis**, *page 3*

Dialysis *(continued)*

HCPCS Code	Description
Z6008	Home training dialysis including professional charges and routine laboratory services
Z6010	Home training dialysis including professional charges
Z6012	Home training dialysis including routine laboratory charges
Z6014	Home training dialysis only

Centers for Medicare & Medicaid Services Exception Codes

HCPCS Code	Description
Z6016	Maintenance dialysis including professional charges and routine laboratory services (CMS approved)
Z6018	Maintenance dialysis including professional charges (CMS approved)
Z6020	Maintenance dialysis including routine laboratory services (CMS approved)
Z6022	Maintenance dialysis only (CMS approved)
Z6036	Home training dialysis including professional charges and routine laboratory services (CMS approved)
Z6038	Home training dialysis including professional charges (CMS approved)
Z6040	Home training dialysis including routine laboratory charges (CMS approved)
Z6042	Home training dialysis only (CMS approved)

Support Services

HCPCS Code	Description
Z6030	Home dialysis (peritoneal or hemodialysis), including laboratory, support services, routine injections, and home dialysis supplies on a monthly basis
Z6032	Installation charge for home dialysis
Z6034	Repair and service for home dialysis

The updated information is reflected on manual replacement page dial end 2 (Part 2).

Travel for Collection of Lab Specimens: Benefit Deletion

Effective for dates of service on or after February 1, 2004, traveling for the sole purpose of drawing blood specimens outside a physician's office, laboratory or hospital setting from a recipient who is homebound or at a nursing facility (HCPCS code X0800) is no longer a Medi-Cal benefit and will no longer be reimbursed.

Organized Outpatient Clinics: Service Limitations

Organized outpatient clinics exempt from licensure based on *Health and Safety Code*, Section 1206, may only bill the following CPT-4 codes for Magnetic Resonance Imaging (MRI):

70540	70553	72146	72157	73218	73718	73723
70542	71550	72147	72158	73219	73719	74181
70543	71551	72148	72195	73220	73720	74183
70551	71552	72149	72196	73222	73721	76093
70552	72141	72156	72197	73223	73722	76094

These services require a *Treatment Authorization Request* (TAR).

Note: Affected clinics will be notified in a provider letter with the effective date of this policy.

This information is reflected on manual replacement page radi dia 15 (Part 2).

Transplant Services: Billing Update

In order to avoid confusion and improve accurate payment, effective February 1, 2004, transplant recipient and donor services always must be billed on separate claims. If there are multiple donors, separate claims are required for each donor. This is not a change to transplant policy but is a change to billing practices. In addition, documentation requirements for transplant claims are updated as shown in the following chart.

Claim Field	**Enter for Transplant Recipient**	**Enter for Transplant Donor**
Patient Name (Box 2 on *HCFA 1500)*	Recipient's name	Donor's name
Birthdate (Box 3 on *HCFA 1500)*	Recipient's birthdate	Recipient's birthdate
Sex (Box 3 on *HCFA 1500)*	Recipient's sex	Recipient's sex
Medi-Cal Identification Number (Box 1a on *HCFA 1500)*	Recipient's ID number	Recipient's ID number
Documentation (Box 19 on *HCFA 1500)*	Transplant recipient	(Name of) transplant donor for (name of transplant recipient). Number of donors (for example, 1 of 1 or 1 of 2).

Please refer to manual replacement pages transplant 5 and 7 (Part 2)

Other Contraceptive Supplies: Billing Example

The *Family Planning Billing Example: HCFA 1500* section has been added to help providers complete claims when billing HCPCS code X1500 (other contraceptive supplies). *Please refer to new manual pages fam planning hcfa 1 thru 3 (Part 2).*

Laparoscopy Rate Adjustment for Assistant Surgeons

A pricing error has been identified on assistant surgeon claims billed for CPT-4 code 47564 (other laparoscopy, surgical; cholecystectomy with exploration of common duct). Claims submitted for dates of service on or after October 30, 2000 for this procedure will be automatically reprocessed, resulting in an increased payment.

Billing Correction: Hypercalcemia of Malignancy

The *Injections* section of the provider manual has been updated to correctly reflect that one of the ICD-9-CM diagnosis codes that may be billed with pamidronate is code 275.42 (hypercalcemia). The manual incorrectly listed 275.4 (disorders of calcium metabolism), which was phased out in 1997. An Erroneous Payment Correction (EPC) is being generated to adjust affected claims for dates of service on or after October 1, 1997.

This change is reflected on manual replacement page inject 33 (Part 2).

Cancer Detection Programs: Every Woman Counts: Claim Submission Reminder

Cancer Detection Programs: Every Woman Counts claims can be submitted either hard copy or electronically using the *HCFA 1500* claim form. Providers who choose to submit hard copy claims must send claims to the following address:

EDS
P. O. Box 15700
Sacramento, CA 95852-1700

Claims submitted to the wrong address will be forwarded appropriately, but processing will be delayed. To order pre-addressed envelopes for claim submission (thereby ensuring that claims are sent to the correct address), refer to the appropriate Forms Reorder Request section of the Part 2 manual or call the Provider Support Center (PSC) at 1-800-541-5555. For more information about claim submission requirements, refer to the *HCFA 1500 Submission and Timeliness Instructions* section of the Part 2 manual.

This information is reflected on manual replacement page can detect 22 (Part 2).

San Diego Medi-Cal Field Office Address and Telephone Changes

Effective October 31, 2003, the address and telephone numbers for the San Diego Medi-Cal Field Office (SDMFO) changed as follows. All SDMFO *Treatment Authorization Requests* (TARs) should now be submitted to the new address.

San Diego Medi-Cal Field Office
9555 Chesapeake Drive, Suite 203
San Diego, CA 92123-6394

(619) 688-4204
Toll-free fax: 1-888-899-2505

The post office box remains the same:

P.O. Box 85344
San Diego, CA 92186-5344

This information is reflected on provider manual replacement page tar field 8 (Part 2).

Medi-Cal List of Contract Drugs Updates

The following provider manual sections have been updated: *Drugs: Contract Drugs List Part 1 – Prescription Drugs* and *Drugs: Contract Drugs List Part 4 – Therapeutic Classifications*.

Additions, effective October 20, 2003

Drug	Size and/or Strength
* FOSAMPRENAVIR CALCIUM	
Tablets	700 mg
* Restricted to use as combination therapy in the treatment of Human Immunodeficiency Virus (HIV) infection.	

Additions, effective January 1, 2004

Drug		Size and/or Strength
DARBEPOETIN ALFA		
* Injection		25 mcg
		40 mcg
		60 mcg
		100 mcg
		150 mcg
		200 mcg
* Injection, prefilled syringe	60 mcg	0.3 cc
	100 mcg	0.5 cc
	200 mcg	0.4 cc
	300 mcg	0.6 cc
* Restricted to use for the treatment of anemia associated with chronic renal failure and in patients with non-myeloid malignancies where anemia is due to the effect of concomitantly administered chemotherapy.		
DUTASTERIDE		
+ CAPSULES		0.5 mg
ROSIGLITAZONE MALEATE/METFORMIN HCL		
+ TABLETS		1 mg/500 mg
		2 mg/500 mg
		4 mg/500 mg
		2 mg/1000 mg
		4 mg/1000 mg

+ Frequency of billing requirement.

Please see **Contract Drugs**, *page 7*

Contract Drugs *(continued)*

Changes, effective January 1, 2004

Drug	**Size and/or Strength**
***** MOXIFLOXACIN **HCL**	
(Ophthalmic solution)	**0.5 %**
ROSIGLITAZONE MALEATE	
+ Tablets	2 mg
	4 mg
	8 mg

Changes, effective February 1, 2004

Drug	**Size and/or Strength**
AMOXICILLIN/CLAVULANATE POTASSIUM	
* Tablets, oral	**1 Gm**
* **Restricted to a maximum dispensing quantity of ten (10) tablets and a maximum of two (2) dispensings in any 30-day period.**	
* Solution or suspension	125 mg/5 cc
	200 mg/5 cc
	250 mg/5 cc
	400 mg/5 cc
	600 mg/5 cc
***** Restricted to a maximum of two (2) dispensings in any 30-day period.	
(NDC labeler code 00029 [SmithKlineBeecham] only.)	
BUPROPION HCL	
Tablets	75 mg
	100 mg
Sustained release tablet	100 mg
	150 mg
	200 mg
* + Sustained release tablet for smoking cessation	150 mg
* Pharmacy must obtain a letter or certificate of enrollment for the patient from a behavioral modification smoking cessation program. Also restricted to a maximum quantity of 60 tablets per dispensing and therapy lasting up to 12 weeks from the dispensing date of the first prescription and two courses of therapy per 12-month period separated by six months.	
(NDC labeler code 00173 [GlaxoSmithKline] only.)	
* DALTEPARIN SODIUM	
Injection, prefilled syringe	2500 IU
	5000 IU
* **Prior authorization always required.**	
LINEZOLID	
Tablets	600 mg
Suspension	100 mg/5 cc 150 cc
* **Prior authorization always required.**	

+ Frequency of billing requirement.

Provider Orientation and Update Sessions

The Family PACT (Planning, Access, Care and Treatment) Program was established in January 1997 to expand access to comprehensive family planning services for low-income California residents.

To be eligible to enroll as a medical provider in the Family PACT Program, the Medi-Cal provider seeking enrollment is required to attend a Provider Orientation and Update Session. When a group provider wishes to enroll, a physician-owner must attend the session. When a clinic wishes to enroll, the medical director or clinician responsible for oversight of the medical services rendered in connection with the Medi-Cal provider number is required to attend.

Office staff members, such as clinic managers and receptionists, are encouraged to attend but are not eligible to receive a *Certificate of Attendance*. Currently enrolled clinicians and staff are encouraged to attend to remain up to date with program policies and services.

Note: Medi-Cal laboratory and pharmacy providers are automatically eligible to participate in the Family PACT Program without attending an orientation session.

Dates and Locations

The following dates and locations are scheduled through April 2004:

February 24, 2004
Anaheim
Radisson Hotel Maingate
1850 South Harbor Boulevard
Anaheim, CA 92802
For directions, call
(714) 750-2801

March 9, 2004
Merced
Ramada Inn
2000 East Childs Avenue
Merced, CA 95340
For directions, call
(209) 723-3121

March 24, 2004
Bakersfield
Double Tree Hotel
3100 Camino Del Rio Court
Bakersfield, CA 93308
For directions, call
(661) 323-7111

April 21, 2004
Stockton
Courtyard by Marriott
3252 West March Lane
Stockton, CA 95219
For directions, call
(209) 472-9700

Check-in begins at 8 a.m. All orientation sessions start promptly at 8:30 a.m. and end by 4:30 p.m. The session covers Family PACT provider enrollment and responsibilities, client eligibility and enrollment, special scope of client services and benefits, provider resources and client education materials. This is not a billing seminar.

Provider Orientation and Update Session Registration

Providers should call the Center for Health Training at (510) 835-3795, ext. 113, to register for the session they plan to attend. Providers must supply the name of the Medi-Cal provider or facility, the Medi-Cal provider number, a contact telephone number, the anticipated number of people who will be attending and the location of the orientation session. At the session, providers must present their Medi-Cal provider number, medical license number and photo identification. Individuals representing a clinic or physician group should use the clinic or group Medi-Cal provider number, not the individual provider number or license number.

Please see **Provider Orientation**, *page 9*

Provider Orientation *(continued)*

Completing Provider Orientation and Update Session

Upon completion of the orientation session, each prospective new Family PACT medical provider will be mailed a *Certificate of Attendance*. Providers should include the white copy of the *Certificate of Attendance* when submitting the Family PACT application and agreement forms (available at the session) to Provider Enrollment Services.

Providers arriving late or leaving early will not be mailed a *Certificate of Attendance*. Currently enrolled Family PACT providers will not receive a certificate.

Family PACT Contact Information

For more information regarding the Family PACT Program, please call the Provider Support Center (PSC) at 1-800-541-5555 from 8 a.m. to 5 p.m., Monday through Friday, except holidays, or visit the Family PACT Web site at **www.familypact.org**.

Part 2

Remove and replace:	can detect 21/22
Remove:	chemo 13 thru 22
Insert:	chemo 13 thru 24 *(new)*
Remove:	dial end 1 thru 4
Insert:	dial end 1 thru 5 *(new)*
Insert new section after the end of the *Family Planning* section:	fam planning hcfa 1 thru 3 *(new)*
Remove and replace:	hcfa comp 15/16 * hcpcs iii 3/4 * inject 33/34 inject list 1/2 *, 9/10 * modif used 3/4 *, 9/10 * non ph 11/12 * oth hlth 7/8 *
Remove:	path hema 3 thru 7
Insert:	path hema 3 thru 6 *
Remove and replace:	radi dia 15 thru 25 rates max lab 1/2 * tar field 7/8 transplant 5 thru 8

* Pages updated/corrected due to ongoing provider manual revisions.